Teton Radiology *advanced medical imaging*
2001 S. Woodruff, Suite 17, Idaho Falls, ID 83404 • tel (208) 524-7237 425 E. 4th N., Rexburg, ID 83440 • tel (208) 356-4888

Medicare Authorization

Name of beneficiary	Medicare number
I request that payment of authorized Medicare benefits be made either to me or on my behalf to TETON RADIOLOGY for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, and its agents any information needed to determine these benefits or the benefits payable for related services.	
Signature	Date

Medicare Medigap Assignment Authorization

Medigap policy number
I request that payment of authorized Medigap benefits be made either to me or on my behalf to TETON RADIOLOGY for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to be released to: _____ **(Name of Medigap Policy)** any information needed to determine these benefits or the benefits payable for related services.

Signature	Date

Medicare_Authorization Rev 2/16

NOTE: Your signature under “Medicare Authorization” on this form will allow our office to submit claims to Medicare on your behalf without requiring your signature on each Medicare claim form. If you have a Medigap policy in addition to Medicare, please complete both sections of this form.